DIVERSIFIED BENEFIT SERVICES, INC.
Dedicated to Excellence in Benefit Management Solutions

105-HRA

Section 105 Health Reimbursement Arrangement (HRA) Claim Form

Mail or fax this form with documentation to:
Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
Fax: (262) 367-5938
For additional claim forms log on at www.dbsbenefits.com

Employee Name (please print): _____

Email Address: _____ **Participant ID Number or Social Security Number:** _____

Name of Your Employer (please print): _____

Employee Signature: _____ **Date:** _____ / _____ / _____

Indicate here if your address/information has changed:

_____

_____

_____

If you are requesting reimbursement from a Section 105 Plan please complete the appropriate information at the right.

SECTION 105 HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT

Amount of reimbursement requested: $_____

Who incurred the expense?
(check all that apply)
- ❒ Employee
- ❒ Spouse
- ❒ Dependent

To expedite your Section 105 reimbursement please complete the top portion of the expense reimbursement claim form and remember to sign your name in the appropriate area.

You must attach proper documentation to this form for reimbursement. An example is an Explanation of Benefits (EOB) report from your medical insurance provider. This report is sent to you by your insurance provider *after* it has been processed.

OFFICE USE ONLY A: _____ D: _____

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement. In addition, by signing this document, I acknowledge and agree that DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient. Finally, I certify that I am aware that I may be reimbursed from the Plan only for my own expenses, expenses of my spouse, and expenses of my "dependent" children as defined by my employer's Plan.